Name:_____ **Date:_____**

Follow-up Plan – Gestational

Recommendations: ❑ Quitting smoking
❑ Dietitian ❑ Flu Vaccination
❑ Public health/Visiting Nurse ❑ Support group _____
❑ Social Worker ❑ Other_____
❑ 2-hour glucose tolerance test (6 weeks after delivery)
Other_____
_____
_____

Behavior change goal:

Specific behavior to be changed _____
How you will change the behavior_____
_____
_____
How will the behavior change improve your health or quality of life**?** _____
_____
_____

Signature_____

Follow -up Assessment

Date:_____

How successful are you with your behavior change goal: ❑ Never ❑ Sometimes ❑ Usually ❑Always
If not successful, why not? _____
Did you follow-through with recommendations/referrals (see above) ❑ Yes ❑ No Why not?
_____
How is your current health ❑ Poor ❑ Fair ❑ Good ❑ Excellent
How frequently do you check your blood sugar?_____and what does it range?_____Do you like the blood sugars you're seeing?_____
_____
What changes, in any, have you made in your eating habits? _____
_____
How often are you physically active? _____
Are you able to do the following?

Oral medication/Insulin use: ❑ Not applicable ❑ Poor ❑ Fair ❑ Good ❑Excellent
Blood sugar meter use: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

How sure are you that you can manage diabetes: ❑ Not sure ❑ somewhat sure ❑Very sure
Date/s of any hospital stays for diabetes since class: _____
My diabetes is a: ❑Disaster ❑Burden ❑Problem ❑Challenge ❑Opportunity ❑Other
Write one example of how you used what you learned about diabetes during the_____ class/es_____
What has changed in your diabetes care since the class/es_____
_____

For Instructional Staff Only

Additional interventions provided/follow-up needed
See Ed. Record)_____

_____

Signature: _____